DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS
FILED FEB 24 1942

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1531

Registration District No. 1 | Primary Registration District No. 1 | Registrar's No. 43

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville (If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution: 402 W. Hickory St (If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether)
In this community Life (years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State Missouri (b) County Adair
(c) City or town Kirksville (If outside city or town limits, write "RURAL")
(d) Street No. 402 W. Hickory (If rural, give location)
(e) Citizen of foreign country? No (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Hopper, Geo. M
3. (b) If veteran, name war X
3. (c) Social Security No. X

4. Sex Male
5. Color or race White
6. (a) Single, widowed, married, divorced widower
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years

7. Birth date of deceased June (Month) 4 (Day) 1860 (Year)

8. AGE: Years 81 | Months 7 | Days 13 | If less than one day hr. min.

9. Birthplace Sullivan Co. (City, town, or county) Mo. (State or foreign country)
10. Usual occupation Retired Farmer
11. Industry or business

FATHER
12. Name John Hopper
13. Birthplace Mo. (City, town, or county) (State or foreign country)

MOTHER
14. Maiden name Margaret Warren
15. Birthplace Ohio (City, town, or county) (State or foreign country)

16. (a) Informant Mrs Robertson
(b) Address Donnelson Ia.
17. (a) Burial (Burial, cremation, or removal) (b) Date thereof Jan 17 1942 (Month) (Day) (Year)
(c) Place: burial or cremation Mt Olivet
18. (a) Signature of funeral director Glenn E. Kastner
(b) Address Green City, Mo.
19. (a) Jan 20 1942 (Date received local registrar) (b) (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month January day 17 year 1942 hour 9 minute 10 P.M.
21. I hereby certify that I attended the deceased from Dec 1941 to January 1942 to ____ 19__; that I last saw him alive on Jan 17 1942 and that death occurred on the date and hour stated above.

Cause	Duration
Immediate cause of death: Cerebral Hemorrhage	
Due to: arteriosclerosis & old age	
Due to:	
Other conditions (Include pregnancy within 3 months of death):	

Major findings:
Of operations
Of autopsy

PHYSICIAN
Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place? (Specify type of place)
While at work? (e) Means of injury

23. Signature W. H. Owens, M.D. (M. or other)
Address Kirksville Mo Date signed 1/17/42

(Licensed Embalmer's Statement on Reverse Side)

RECEIVED
District Health Officer No. 10
District File Number 2-42-373
Date Filed FEB 20 1942

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....

working under my personal supervision.

Signed Glenn E Kent

Licensed Embalmer No. 1769

P. O. Address Green City, Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.

No. 2B
(—8-21-41
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DEPARTMENT OF COMMERCE
BUREAU OF THE CENSUS

MISSOURI STATE BOARD OF HEALTH

STANDARD CERTIFICATE OF DEATH

State File No. 1521

Registration District No. 1 Primary Registration District No. 1 Registrar's No.

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

1. PLACE OF DEATH:
(a) County Adair
(b) City or town Kirksville
(If outside city or town limits, write "RURAL" and name of township)
(c) Name of hospital or institution:
(If not in hospital or institution, write street number or location)
(d) Length of stay: In hospital or institution (Specify whether
In this community years, months or days)

2. USUAL RESIDENCE OF DECEASED:
(a) State (b) County
(c) City or town
(If outside city or town limits, write "RURAL")
(d) Street No.
(If rural, give location)
(e) Citizen of foreign country? (Yes or No)
If yes, name country

3. (a) PRINT FULL NAME Geo. Wm. Hopper
3. (b) If veteran, name war
3. (c) Social Security No.

4. Sex M
5. Color or race W
6. (a) Single, widowed, married, divorced W
6. (b) Name of husband or wife
6. (c) Age of husband or wife if alive years
7. Birth date of deceased June 4 (Month) (Day) 1864 (Year)

8. AGE: Years 81 Months 7 Days 13 If less than one day hr. min.

9. Birthplace (City, town, or county) (State or foreign country)
10. Usual occupation
11. Industry or business
MOTHER FATHER
12. Name
13. Birthplace (City, town, or county) (State or foreign country)
MOTHER FATHER
14. Maiden name
15. Birthplace (City, town, or county) (State or foreign country)
16. (a) Informant
(b) Address
17. (a) (Burial, cremation, or removal) (b) Date thereof (Month) (Day) (Year)
(c) Place: burial or cremation
18. (a) Signature of funeral director
(b) Address
19. (a) June 20, 1942 (Date received local registrar) Mrs. L. Wayne (Registrar's signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Jan day
year 1942 hour minute M.
21. I hereby certify that I attended the deceased from , 19 to , 19 ;
that I last saw h alive on , 19 ;
and that death occurred on the date and hour stated above.

	Duration
Immediate cause of death	
Due to	
Due to	
Other conditions (Include pregnancy within 3 months of death)	

Major findings:
Of operations
Of autopsy

PHYSICIAN

Underline the cause to which death should be charged statistically.

22. If death was due to external causes, fill in the following:
(a) Accident, suicide, or homicide (specify)
(b) Date of occurrence
(c) Where did injury occur? (City or town) (County) (State)
(d) Did injury occur in or about home, on farm, in industrial place, in public place?
(Specify type of place)
While at work? (e) Means of injury

23. Signature (M. D. or other)
Address Date signed

SUPPLEMENTARY

5-1531